# STATE OF MAINE

# OCCUPATIONAL THERAPY PRACTICE

# APPLICATION FOR LICENSURE

• Permanent Occupational Therapy Assistant



Department of Professional and Financial Regulation Office of Licensing and Registration 35 State House Station Augusta, ME 04333-0035

> Office Telephone: (207) 624-8626 Office Facsimile: (207) 624-8637 TTY/HEARING IMPAIRED (888) 577-6690

Email: jennifer.l.mooney@maine.gov

Office located at: 122 Northern Avenue, Gardiner, Maine

# **APPLICATION GUIDE**

# I. REQUIREMENTS FOR PERMANENT LICENSURE-OCCUPATIONAL THERAPY ASSISTANT

Applic	icants for permanent licensure must submit:			
	Application with all sections completed;			
	Fees: All Checks/Money Orders should be made payable to the "Treasurer, State of Maine". If paying using a credit card please use the Credit Card form at the end of the application. All Fees can be in one payment;			
	<ul> <li>\$60.00 Application Fee</li> <li>\$70.00 License Fee for Occupational Therapy Assistants</li> <li>\$15.00 Criminal History Records Check Fee</li> </ul>			
	Two professional references addressing ethical practice—See board Reference Forms;			
	A completed supervisor's affidavit**;			
	Verification of licensure from sending state (if applicable); and			
	Verification of certification form completed and signed by NBCOT. (Form is available at <a href="http://www.nbcot.org/verification_orderform">http://www.nbcot.org/verification_orderform</a> )			

# II. <u>LICENSE TERMS</u>

Licenses are issued for a two-year period and are renewable biennially on March 31st of every odd numbered year.

\*\*Please note: the Board must be notified of any change in the temporary licensee's supervisor within 15 days. Such notification shall be in the form of a signed supervisor's affidavit form and mailed directly to the board. Please refer to Board Rule Chapter 5, Section (3)(4)(B)

Applications will not be processed until all documentation is received. It is the responsibility of the applicant to see that all documentation is completed and returned to the board for consideration. If you need any further information please contact Jennifer Mooney at (207) 624-8626 or email at <a href="mailto:jennifer.l.mooney@maine.gov">jennifer.l.mooney@maine.gov</a>



# STATE OF MAINE DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

## **Board of Occupational Therapy Practice**

35 STATE HOUSE STATION AUGUSTA, MAINE 04333-0035

Office Use Only License #				
Cash#.				
Check #				
4440	1422	\$70		
4440	1446	\$60		
4440	2619	\$15		

ANNE L. HEAD DIRECTOR

FAX: (207)624-8637

## APPLICATION FOR PERMANENT OCCUPATIONAL THERAPY ASSISTANT LICENSURE

#### **Notice regarding Social Security Number Disclosure**

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.

#### **Notice regarding Public Information**

This application is a public record for purposes of Maine's Freedom of Access Law, 1 MRSA §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, mailing address and other information listed on this application may be posted on the State's website.

Name:				
First	Middle	Last	Maiden	
Any other names used:				
Address:Street or PO Box			County	
Street of PO Box			County	
City/town		State	Zip code	_
Home phone number:		Work phone number: _		
Date of birth:	Socia	ll Security #:		



NBCOT certification number (n/a for temporary licenses):							
Examination date:							
Current or intended place of employment:							
Name		Stree	et addre	SS			
City/town	State	Zip code			Tele	ephone	#
Employment: reflecting occupation	onal therapy	practice for the	e last th	ree yea	ars o	two jo	bs:
Facility	Address			Positi	on		Dates_
Have you ever been licensed in a	nother state	or territory?		'es		No	
State:		_ License#: _					
Date Issued:							
Date issued.		Expiration L	ale				
Has any state board governing the examination or licensure?	ne practice of	f occupational	therapy	/ denie	d you	ır applio	cation for
	Yes			No			
If yes, please attach explanation							
Has your license ever been susp	ended or rev	oked by any s	state?				
	Yes		П	No			
If yes, please attach explanation							
CDIMINA	NI HISTORY	RECORDS CH	ECK DD	OCEDI	IDE		
Pursuant to 5 M.R.S.A. §5301-5						to take	into
consideration an applicant's cr	iminal histor	y record. The	Office o	f Licen	sing	and Re	gistration
requires a criminal history reco	ords check as	s part of the ap	plicatio	n proce	ess fo	or all ap	plicants.
Have you ever been convicted or	f a crimo oth	or than a mino	r traffic	violatio	m2		
Thave you ever been convicted o	Yes			No	111:		
If yes, please describe in detail the well as a letter from you explaining							dgment(s) as
I have read and completed this	s application	and I attest	that all	the inf	orma	ation is	true to the
best of my knowledge.							
Applicant's signature:				Date	:		



# STATE OF MAINE DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

## **Board of Occupational Therapy Practice**

35 STATE HOUSE STATION AUGUSTA, MAINE 04333-0035

ANNE L. HEAD DIRECTOR

# **VERIFICATION OF LICENSURE IN OTHER STATE**

# **DIRECTIONS TO APPLICANT:**

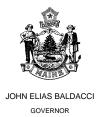
OFFICE PHONE: (207)624-8626

Complete front portion of form and forward one to each state where you hold or have held a license to practice occupational therapy.

To: State Board	I am applying for a license in the State of
Maine to practice as a	I was granted license #
license type on	by the State of
The Maine Board of Occupational Therain the State of	apy Practice requests that I submit verification that my license is in good standing.
•	ny information in your files, favorable or otherwise, directly to py Practice. Your early attention is appreciated.
	Signature:
	Print Name:
	Date:

Note: Because some States charge a fee to complete this form, you should check with each State before mailing.





# STATE OF MAINE DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

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# (To be completed by State)

# DIRECTIONS TO STATE BOARD: Please complete and return form to the following address: MAINE BOARD OF OCCUPATIONAL THERAPY PRACTICE #35 STATE HOUSE STATION AUGUSTA, MAINE 04333-0035

Name of Licensee:		License Type: _	License Type:		
License #:		Date Issued:			
License Current: Yes	No	Expiration Date:			
Name of Exam Taken:lf no exam was taken, how was lide.  1. Grandfathered:  What were the requirements for e	cense obtained 2. Endorseme	nt/Comity:	_ State:		
Are there any pending complaints Yes No					
Have there been any other action	s taken agains	t this licensee?			
Yes No					
Explanation of above if answer is	yes:				
•	•				
	Signature and	Title:			
State Seal	Date:				

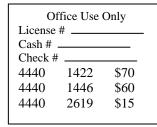




#### STATE OF MAINE DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

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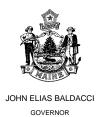
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### **AUTHORIZATION OF CREDIT CARD PAYMENT**

Fees owed to this Department may be paid by the use of a credit card. If you wish to pay your fee(s) with your credit card, please complete this form and send it with your application. Payment through credit cards will not be processed without this authorization form.

Name: (applicant fees being paid for)							
Mailing Address: (applicant fees being paid for	)						
City:	State:	Zip Code:					
County:	II.	Telephone #: ()					
Name of cardholder: (if other than applicant)  Mailing Address:	(if other than applicant)						
(if other than applicant)							
City:	State:	Zip Code:					
I authorize the State of Ma Licensing and Registratio		Professional and Financial Regulation, Office of					
Visa Maste	erCard	Card number					
Expiration date:	/in t	the amount of: \$					
Signature:		/					





# STATE OF MAINE DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

## **Board of Occupational Therapy Practice**

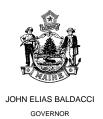
35 STATE HOUSE STATION AUGUSTA, MAINE 04333-0035

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# **REFERENCE FORM**

Name of applicant							
In what professional capacity do you know the applicant?							
How long have you known the applicant?							
Are you related to the applicant? If so, how							
Please give a brief statement of your knowledge of the applicant's ethical practice of occupationa therapy:							
Date:Signed:							
Printed name and title of reference:							
Mailing address:							
Telephone number during work hours:							





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### SUPERVISOR'S AFFIDAVIT

(Board requires an updated form for a change in Supervisor *or level of supervision* within <u>15</u> days of the change)

Please provide a separate form for each place of employment

SECTION A (Completed by the S	Supervisor)	
I,(Print Supervisor's Name)	a	assume supervisory responsibility for
(Print Name	Temporary Occupational	Therapist or Occupational Therapy Asst
**I will provide supervision at the	following level, as defined in th	e Rules of Occupational Therapy
Practice: Direct	Close Routine	General
I will immediately notify the Board person.	I of Occupational Therapy Practi	ce of any change in supervision of thi
Date:	Supervisor's Signa	ature License No.
Telephone Number	– — Pla	ace of Employment
SECTION B (Completed by the S	Supervisee)	
I,(Print Supervisee Name)	assume supervision from(Pr	rint Supervisor's Name/Licensed OTR)
I will immediately notify the Board o	f Occupational Therapy Practice o	f any change in my supervisor.
Date:	Supervisee's Signature	Place of Employment
** Board of Occupational Therapy P	ractice rules are available at www	.maineprofessionalreg.org

